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Rehabilitation Research and Training Center on
Employment Policy for Persons with Disabilities

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Public Policy Forum**

**Prospects for Harnessing Private Sector
Capabilities to Improve Employment for
Social Security Disability Beneficiaries**

Speakers:

Winthrop Cashdollar
America's Health Insurance Plans

Ken Mitchell
Unum Corporation

Discussant:

John Lancaster
National Council on Independent Living

Moderator:

David Stapleton
Cornell University Institute for Policy Research

For further information about this policy forum contact:

Michele Cowen
tel (607) 254-8311
email mtc11@cornell.edu
web www.ilr.cornell.edu/edi

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The Co-Principal Investigators are:

Susanne M. Bruyère—Director, Employment and Disability Institute, School of Industrial and Labor Relations, Extension Division, Cornell University

Richard V. Burkhauser—Sarah Gibson Blanding Professor and Chair, Department of Policy Analysis and Management, College of Human Ecology, Cornell University

David C. Stapleton—Director, Cornell University Institute for Policy Research

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Welcome

Brewster Thackery:

My name is Brewster Thackery and it is my great pleasure to welcome you here on behalf of AARP in general and in particular on behalf of the AARP disability and interest group. This is a fairly new organization. Some of you may have had a chance to come to our 16th anniversary of the ADA that we held last summer. We're going to have a lot more events and we certainly are eager to take opportunities that we can such as this to welcome the disability community and people working on disability issues to AARP. So you remember who we are, we have some pens in the back of the room.

I know a good number of you already because prior to coming to AARP a couple of years ago I worked in government affairs at The National Institute on Disability and while I was there our organization worked on issues with the disability community and the one that always caught reporter's eyes and everyone's eyes was the number of people who are employed who have disabilities. We always came out in the low 30's, 32 to 35% at a time it would be in the 80's for the rest of the population. It's a very compelling issue and here at AARP we're concerned with employment issues, people at 50 plus in America and also people with disabilities because there is a heavy correlation between people who are 50 plus and people who have disabilities. I want to thank my colleagues in the Office of Social Impact Economics group who are working with older worker issues and who generally helped us out today by supplying cookies, coffee and iced tea in the back of the room which we welcome you to avail yourselves of.

We're very appreciative of everyone who is represented today here at AARP. It's going to be a wonderful forum and very much look forward to sharing it with you.

Susanne Bruyère:

Good afternoon. ***My name is Susanne Bruyère and I am the project director of The Rehabilitation Research and Training Center at the Employment Policy for People with Disabilities*** and at this point, a third of the sponsorship of this event today. We have been in copartnership with the American Association of People with Disabilities as you heard from our gracious host today from AARP .

This event is entitled Prospects for Harnessing Private Sector Capabilities to Improve Employment for Social Security Disability Beneficiaries. We have brought with us some related materials to this topic. We have multiple copies, enough for everyone to have a packet of Cornell materials and samples of other products. When you leave, if the samples are still left, please feel free to take them but I also encourage you to e-mail me if you want copies of these or other papers you see. We'll be happy to send you to the appropriate link on our website and get you one of the over 60 papers that we have that is related to the work of the Employment Policy Center.

This center, as the materials show, is funded by the U.S. Department of Education, National Institute on Disability Rehabilitation Research and we have a representative from NIDRR, our Project Officer Edna Johnson and her colleague Margaret Campbell here today. And Phil. Hi. I'm sorry. I didn't see you. Welcome.

I would like to tell you a little bit about our other programs and I'm not sure I know how to advance this.

My colleague David Stapleton is going to introduce our excellent panel of speakers today. We have with us Winthrop Cashdollar, Ken Mitchell and John Lancaster. There are bios about these gentlemen in your materials but I'm going to let Dave do a more thorough introduction and we'll just use this opportunity to tell you the we have some upcoming related policy forums. The dates of those, the titles and the locations are in the materials that you have.

I also want to acknowledge that you may hear some disruption because we do have people on the phone today. This is the first time that we are trying to provide these policy forums to those who cannot be here in person.

So I apologize for the delay in start up. We're trying to work out the logistics of our first attempt to do an audio conference access, but also webinar access and we have not had enough experience to get the kinks worked out. So I apologize and I appreciate your patience with this. We're very excited to make these materials accessible to a broader audience. With that, I'll pause and Dave, I'll turn it over to you to do an introduction of our speakers.

David Stapleton:

Thanks everybody for joining us today and especially thanks to those who are listening by phone. I only wish we could somehow get the surplus cookies that we have out to you in some way.

For some time we have been quite concerned about what appears to be the decline of communities of working age people and disabilities as a whole. To the best of our knowledge, their employment rate has been declining steadily since the mid 1980's and their household incomes have also been shrinking both absolutely and certainly relative to the rest of the population. Further, federal and state expenditures that support this population are growing at a rate which is far greater than the rate of the federal expenditures in general.

The aging of the Baby Boomers, myself included, is also going to make the situation worse because we're entering the period in our lives where we are most likely to experience disability onset.

Personally I think we are seeing these trends because the programs discourage

work and are extremely fragmented. Starting with the 1990 passage of the ADA, there have been substantial attempts to further programs to help working age people with disabilities become more self-sufficient and benefit in the fruits of our economy, and that's a lot of what our work at Cornell is about. Ticket to Work, Medicaid Buy-In program and numerous smaller issues have been launched and I'm sure most of you are familiar with at least some of these. Progress, in my opinion, is excruciatingly slow and I as a result started thinking about whether there are ways to make more rapid progress by somehow harnessing capabilities in the private sector.

Private disability, disability management vendors and employers themselves have several advantages relevant to public programs addressing the needs of people with disabilities. They have the ability to innovate quickly and respond to changes in developments. They have the ability to change the workplace in ways that will reduce delay or delay the onset of disability or support return to work after disability onset. And they have the ability to identify employees in the early stages of disability onset and work with them before they become disconnected from their employer. I think these are all very important capabilities. So the question is, is there some way that the government can harness those capabilities to take a quantum leap forward in the transformation system to offer better opportunities to people with disabilities to be self-sufficient and share in the fruits of the economy?

I'm not convinced that there is. But I think the prospects are important enough that we need to seriously consider them and vigorously investigate them and debate them. I think you're going to hear some interesting ideas from a couple of our speakers today and I will also be very interested to hear what others have to say about them in discussion at the end. I also want to mention that in your folder you should find a short policy brief on this topic that we wrote. And there is a paper that wasn't quite ready for prime time today, but will be available fairly soon, and I will create a list where you can sign up. Give me an e-mail address and we'll send you an electronic copy when we're ready to release it. So let me now turn to the speakers and minimize my introductions. We have put a great panel together. The first speaker is going to be Winthrop Cashdollar. He's the Executive Director for Disability Insurance of America's Health Insurance Plans and I should say that we have been doing some work on this topic in the policy brief that we wrote, which was funded by them.

So as it says here in the biographies, there are more complete biographies in one of the folders in your pamphlet, and I hope everybody got a pamphlet. It says he spearheaded industry efforts to develop public and private partnerships between private insurers and Social Security Administration. So when he gets up here to speak, if you don't want to get hit by his spear, you should duck.

Ken Mitchell is the Vice President of Development Technology for Unum

Corporation in Chattanooga, Tennessee, where he has been since 1997. He is someone I have known for a long time and has appeared at many events around Washington and I think is really forward in terms of thinking how we can improve the delivery of services to workers with disabilities, or that experience disability onset.

John Lancaster, who many of you know I'm sure, is the Executive Director on The National Council on Independent Living. We will provide a commentary on the individual speakers today and then after that we will throw it open to the rest of you for questions and answers.
So Winthrop, please.

Panel

Winthrop Cashdollar:

Well, thank you very much, Dave. And I want to acknowledge that yes indeed we have been working together on some disability income issues. I'm very grateful for the work that you have done and a lot of what I say draws upon your excellent work both recently and far back.

I want to also thank the sponsors of this event, AARP and NIDRR and my good friends Margaret Campbell and Andy Imparato. It's always a pleasure to see you. I stepped out of the private disability insurance world and into this world on a few occasions. I realize that our communities, they touch and they are united by a common word, "disability" and I think that we have begun to explore and establish that there is a common ground as well, and that is what I want to explore with you today.

I think and hope that there are prospects for harnessing private sector capabilities to improve the SSDI program and I'm very interested to see what this audience thinks of the beginning of that exploration and what you have to say about it. As Dave mentioned, I'm the Executive Director of the Disability Health Insurance Plans. AHIP provides more than 1300 programs to more than 200 million Americans and those coverages include of course disability insurance, but also medical expense insurance, multiple care insurance, dental insurance and very supplemental insurances as well.

I also want to note that we do represent a majority, a significant majority, of the disability insurance market, and the leading disability insurers in the United States and Unum is certainly a leading company, a very important company, a very important member. I also have had the pleasure to work with Ken Mitchell in a number of different cooperative endeavors and am delighted to be with him today. I won the coin toss and I get to kick off. So I'm glad that he will be talking the ball after I pass it on to him.

I'll be repeating a little bit of what Mr. Thackery and Dr. Stapleton touched upon, but it's well known that the Social Security disability program is under increasing strain. I looked back at the 2006 Trustees Report and saw that although the Social Security programs together do pass the short-term test of financial adequacy, they have badly failed the long-term test. And although on paper the trust funds are supposed to be solvent, if you will, until about 2040, the date at which the tax revenues into the trust funds are exceeded by benefit outlays is something like 2017. And that's a much more important date than the "solvency date" because that's when policy changes will need to already begin heading off the insolvency problem.

Dr. Stapleton mentioned some of the public policy initiatives undertaken to try to begin to address the solvency issue for the Social Security trust funds and to approve some of the outcomes for the SSDI program. In his words, I think that the progress has been excruciatingly slow and it looks like we will have to shift into high gear to take on the challenges that Social Security faces and the Social Security disability programs.

One of the reasons I'm here today is because my organization and the disability insurers we represent think that it's worth exploring, well worth exploring, whether private disability insurers can take steps and partnership with the Social Security Disability Insurance program that would improve the outcomes for that program and improve claim management and include returning to work outcomes and improve the bottom line.

Before I address this slide, let me say that I understand that a previous installment in this series had the audience hear about the Social Security Advisory Board report from last September and that report is Disability System for the 21st Century. And we have been encouraged by that report to undertake our exploration of what the private industry might do to transform the disability system into one appropriate for this century.

I don't know if everyone here was a party to that previous installment. So basically what the SSAB and Social Security Report were saying was that the program could be made to focus more thoroughly and more effectively-- the SSDI program on the capacity for individuals to remain at work, to return to work-- and they began to explore ideas about adding to the current system, a front end that would encourage early outreach, early intervention and for prime time today.

This slide represents the employment status, the disparity between employment status of men, and households without work limitations and with. And again, as Mr. Thackery noted, the employment rate for men with work limitations is something like half that of men without work limitations and the disparity has been getting wider, impacting trends for the Social Security disability insurance program. This represents an increase in eligibility by certain age groups between

the period of 1990 and 2002, a dozen years and you can see, just to pick a couple of age groups, over those dozen years -- well, for all age groups, the participation is up by more than 40% and for instance the 50 and the 54 age group, it's up by about 33% and for the 55 to 59, it's up just a little over 30%. That's a tremendous growth in the program in a dozen years and I can show you how those are continuing past the year 2002.

This is just a picture of the travel of the Baby Boom generation through the age brackets. I know it's a little bit difficult to read. But the upper left-hand picture is 1990. The upper right is the year of 2000. The lower right is the year 2020. I have seen these pictures and I'm sure you all have too. But I never really considered how profound this all is.

Just eyeballing the graphs according to my back of the envelope calculations, in 1990 it seems that there were 30 million Americans in the age group from 50 to 64 that actually looks like it dipped down a little bit in the year 2000 but in 2010, the number approaches 60 million Americans in the 50 to 64 age bracket. In 2020 it passes over 60 million Americans. So it's the entire 77 million Baby Boomers are just traveling through that age bracket and as a couple of previous speakers have noted that has implications because of the propensity for people in this age group to suffer some kind of disability or work limitation.

This slide quotes one particular study regarding the number of adults, the percentage of adults in their 50's who have a work limitation. And the additional 1/3, 34% who experience work limitation onset during the next 10 years.

A word about a few of the policy initiatives...Ticket to Work. The Ticket to Work is certainly a good and noble idea and certainly supported by my association and our disability members but it has frankly not set the world on fire.

We were pleased to see the changes forthcoming to improve the incentives for the program, at least as they play on ticket takers. But, again, there is a question as to whether the program will reach more ticket holders.

SSA demonstrations...The Social Security Administration is very aware of the challenges that bear down upon it and that they undertake to experiment or explore the number of interventions that they think would improve their outcomes, either for people remaining at work or returning to work. And so they have gotten a handful of demonstrations. Again, progress has been very slow. I understand that not all elements of the government have been supportive and things have gotten a little bit bogged down so there is a demonstration of accelerated benefits, mental health treatment and there is a special demonstration for people with H.I.V./A.I.D.S.

It looks like the benefit offset national demonstration may get underway this year.

I don't have these points up there really to discuss policies, but just to acknowledge that the Social Security Administration is doing what it can under its current authority, with its current resources to try to find ways to influence its outcomes and its return to work efforts.

Again, going back to the acknowledgment by the Social Security Administration that interventions are needed and the work of the Social Security Advisory Board, we have begun to consider how the private sector, the private disability insurers, can form a kind of partnership with the Social Security Administration that would be a mutual benefit and benefit to SSDI applicants, SSDI claimants and funders of the public disability system.

We envision that there are core competencies and tools prevalent in the private sector that are currently unavailable or not yet at work in the public sector that can be applied for the benefit of the public program.

We think that these competencies and tools can be brought to move program administration and risk management further and faster in the right direction, further and faster than current initiatives can.

We see advantages to making use of what's already available in the private sector as opposed to recreating it in the public sector, and we think that using these current existing capabilities and tools and resources can make the experiment go much more quickly. At this point, we are very much in the conceptual stage. We would like to begin a dialogue with the leadership of the Social Security Administration, the new leadership, Commissioner Astro and we have begun to lay out conceptual options for what partnerships might look like. Excuse me. I'm getting a little trigger happy here.

The first option which I'll discuss in a little bit more detail is improve sharing of disability claim information. That is allowing the public program to take advantage of claim information that has already been compiled by the private disability insurers. A second option is more devoted to return to work, improving the employment prospects for SSDI applicants and SSDI claimants.

And third is private administration of the public disability benefits and I do want to make a point here before I go on, that what we're not talking about here is we are not talking about privatizing Social Security. We're not talking about privatizing the SSDI program or privatizing the adjudication. I don't carry that brief. I don't carry a brief about private accounts or any such thing.

In fact, I can tell you that my members are not considering and do not wish to privatize the adjudication process. So I want to make that point very clearly.

So with that, we'll talk briefly about what these concepts and these options might

look like.

The first option, the improved sharing of disability claim information. For private disability claimants who become SSDI applicants or SSDI claimants, private disability insurers come into a wealth of information that potentially may be of real service in terms of speeding adjudication and frankly -- one item that I know that the Social Security Administration would be very interested in is improved medical information and documentation.

They are going to great lengths already to boost the availability and quality of medical information that goes into their adjudication process, so that is something that we are trying to see if we can share with them in a way that will help the public program.

In talking with our members, I know that there's been a change to the public program adjudication process that attempts to make rapid decisions for certain kinds of disabilities. But in the private sector there are board certified physicians who are able to give definitive diagnoses for presumptive case of disability and that is something that we think really helps speed the adjudication process. Move some cases through very quickly and allow more resources to be devoted to other cases.

The public sector very often has independent medical examinations performed to support disability claim adjudication and also functional capacity examinations. Finally, we have heard cases where private disability insurers knew of actual return to work, but the Social Security Administration did not.

So I think you can still read all of the points here, but what we're talking about is taking information that private disability insurers already have and finding an efficient way to put it into the hands of the Social Security Administration to improve their adjudication process.

I think people are very well aware that the Social Security Administration has a disability services initiative that they are testing out and implementing in New England and as it happens, tomorrow I and some of my colleagues are going up to Baltimore to talk to the Social Security Administration about just this sort of thing, focusing on medical information. They really see a need to improve the quality of their medical information and we're going to start talking to them tomorrow about a way to provide that to them. We want to figure out how we can address all the security, all the privacy and all the interoperability issues that are involved in that.

So this is an option that frankly I think the Social Security Administration already thinks might be worth pursuing.

A second option that we conceptualize is fee-for-service menu and intervention and return to work. This is actually pretty straightforward.

Imagine a scenario under which the Social Security Administration and private disability insurers would get together and come up with a menu of services that would be provided on a fee-for-service basis for applicants or claimants identified by the Social Security Administration. And we only have just begun to figure out what a menu might be and that's all we have at this point is a menu. And one menu item would be a very early evaluation of the medical and functional status of new SSDI applicants and this is something that is very much in keeping with the Social Security Advisory Board and they see a real need for this.

Another menu might be comprehensive rehab, return to work plan, actual rehabilitation return to work management for applicants and claimants. And outreach, planning and follow-up with employers to implement and support return to work.

One of the signal observations in our consideration of this is although the Social Security Administration has connections with all employees on the FICA tech side, they have no connection whatsoever with employees on any kind of risk management or return to work. Whereas leading insurers have an excellent capacity to do this and that's very much what Ken Mitchell will talk about.

Another challenge is carrying out the periodic review reassessment and we would like to discuss with SSA whether or not there is a roll to boost the capacity to carry out periodic review. And finally possibly private insurers can help SSA with fraud investigation and documentation.

We have one final option that we have begun to conceptualize. This would be private administration of public disability benefits.

We think that we could talk to the Social Security Administration about a demonstration that would show the potential for value added by a private entity managing the public -- workers would be given a choice. They can opt to have their benefit administered as is currently done by the SSA or have it administered by a private disability insurer or anyone in the private insurance industry.

And we have begun to consider how a demonstration might be constructed to incentivize and reimburse, reward the private insurer for the impact on the trust funds, for customer satisfaction, for appropriate and accurate administration. This is an important point.

This is all conceptual, but an important part is that private insurers would be required to award and pay SSDI benefits following SSDI definitions and rules.

Benefits would be paid from the trust funds, at least that's what we're envisioning at

this point. It should be an incentivize for the trust fund and we think the structure might be built in such a way that it would encourage integrated management and private and public disability management.

I'm going backwards a little bit at this point. In term of any partnership between the public sector and the private sectors on this, we're very well aware that we have made suitable arrangements to authorize the sharing of claimant and applicant information. Very careful measure would need to be placed in the security of the information. And we would have to have appropriate guarantees against unintended and inappropriate uses of claimant and applicant information.

And there is not currently interoperability between the public and private sector. And it's a hurdle but I think it's one we should explore and see if we can clear that road.

Okay. That concludes my remarks and I think I'll yield the floor to Ken Mitchell.

Ken Mitchell:

It's very nice to be here with a variety of people that are economists, public policy specialists and individuals who know about social insurance. I am really none of those. I am just simply a return to work guy that's been asked to make some comments and some observations. And one thing I do well is certainly to try to establish connections. Now, my role this afternoon is to identify some of the key connections between the public and private relationship that need to be attended to, that need to be developed and certainly need to be made clear. And there are three points in my career that have been very useful in helping me to understand this public/private relationship. The first one was when I heard the term "cats don't bark." There was a term that I heard in 1980 saying simply this, "Insurance companies don't give people back the work, so why would we include return to work as part of SSDI?" It's a program designed to pay a benefit. Private insurance is an insurance company that's designed to pay a benefit and to manage risk and there is the first question, "Is a Social Security disability insurance an insurance that manages risk as the private industry does?" Often times those are different elements. But think about that, "cats don't bark," a very simple, almost nonsensical phrase that we wouldn't expect a cat to bark, nor should we expect the insurance company to give people back the work.

The second term I heard was offered by Jeffrey Palmer in New Zealand and is dealing with the politics of incapacity and I'm going to be spending some time on that because politics of incapacity becomes a very important element as we discuss public and private relationship. That is the relationship that comes out of this and that is the self- interest of the taxpayer, the interest of the stockholder of a private group and the self- interest of the consumer group.

The other self- interest may be the bureaucratic interest of the organization to

protect jobs, to offer resources, to consolidate a political base. Those have to be taken into consideration because oftentimes when we deal with employers and individuals around disability, we have a collision of self-interest. And those have to be paid attention to.

And so from that standpoint as we start to unfold this public/private relationship, we have to understand the various politics of self-interest and the politics of incapacity and we'll get to that as we go forward. But ultimately I want to pay attention to a very important statement that I received maybe my first month as a rehabilitation counselor back in 1970 where I had an individual who was just out of his spinal cord treatment and he was trying to go back to work. He was on Social Security and he said, "Ken, help me. I'm being held hostage by this disability system." And that was my first introduction to a disability hostage.

And what about the current system-- Both public and private employers, health care providers and employees of individuals hostages to a particular system? We have to pay attention to that. We have to understand that and understanding that disability hostage is one where we can look at the politics of incapacity. One of the areas that we have to pay attention to and you saw from Winthrop's presentation is that we have to deal with efficiencies and effectiveness of managing the claim itself. Also within that is an embodiment of accountability.

In the private sector, we have a very specific person, a group of specific people that are made accountable for helping the individual go back to work. That does not exist in the Social Security disability insurance system in the public system. Accountability and focus of attention is an important element in the ability to return a person back to work.

Secondly, the effectiveness of being able to move a person from the time a claim is offered and submitted to the time a decision is made. There are many bureaucratic steps that are taken in terms of sharing information. But one thing I can guarantee you is that the longer that goes, we have a grumpy, unhappy person going through a process.

We call it the insurance paradox. It takes six months or maybe two years to prove that I'm disabled and I can't work and then all of a sudden you come back the next day I get my award and ask me to go back to work. Well, if that doesn't annoy me, I don't know what does and so we have to pay attention to that juxtaposition of the effectiveness of the process and the motivation and the momentum that the individual has.

Oftentimes we can deal with return to work as really dealing with that whole issue of inner "ya", what keeps moving moves. What is not moving is hard to move forward and so from that standpoint, organizational efficiency is an important part of that process.

Also when we talk about the return to work and the politics of self- interest and the politics of incapacity we have to understand who the stakeholders are, taxpayers are stakeholders, policy owners are stakeholders.

The intention is we have to understand the relationship between the three and where that organization is responding to. Is the Social Security Disability Insurance for the consumer?

For the individual disabled? Or for the taxpayer or is it for other partners? What is the role of that organization?

What is the role of our private insurers and how they connect and disconnect? We have to pay attention to who is coming into the system. Winthrop showed a very nice system of the aging work force, it needs to be critical. But you saw that there is a bipolar, bimodal approach that we have a large number of younger people coming into that system. One of the common problem that we make that helps to keep people held hostage in the system is we offer a system that is one thing for all people and it doesn't work that way. There has to be a capacity to offer a program reflective of the career development needs of ages. A 19 and 20 year old with no work experience should not have the same experiences of a person who is 55 or 58 with 30 years of experience. It has to meet those particular needs.

Keeping the individual productive and independent in the workplace, employers now are increasingly looking at the nature and notion of helping to keep people working longer because of changes in their employment status and the manpower capacity to meet certain production needs. Every employer we're working with today is dealing with appraisals, trying to help an individual to keep from becoming diabetic, heart disease, arthritis, other types of conditions that effectively hold a person in a position where they can't do their work, ultimately passing over the threshold of going on to a disability because they can't meet certain functional capacity needs. Employers pay attention to that and so we have to respond to that and support that in a way of making sure that a person or employer has a clear understanding of what a person can do and can't do.

We also want to be able to reap the benefits of benefit cost and that social safety net. Oftentimes in thinking that it is either, or, yes or no, that the Social Security is a social safety net. Private industry is also a private enterprise and is a social safety net with a slightly different feature, different opportunities and little different type of focus. But in fact it provides that net, that social net financially to allow people to maintain their dependence and to focus on where their options and opportunities are later on.

And finally the last two things in the politics of incapacity we need to pay attention to is the idea of being a disability hostage and being held hostage by the disability

system is that we're dealing with competing definitions of disability. When we go over what an employer may ask and we have an individual who is disabled. They say wait a minute, if they're disabled, they can't work because I have insurance that says if you can't work, you get disability insurance. Maybe we shouldn't call it a disability insurance. Maybe we should call it independent insurance in a way that allows individuals to create opportunities to maintain that I know their independence, productivity and being able to match up with the employers and being able to use those particular resources. So changing the definition of disability becomes to the employer the point where you say I'm not even going to deal with. If that term becomes involved, then I'm just going to circumvent it and move on to other areas and then finally we need to look at the incentives and disincentives to change and within that we have to be smart, we have to be able to look at and leverage the type of opportunities that make a difference for employers as well as individuals that are in the insurance program.

A good example of this is in our Unum UK affiliate, Unum Group includes not only Unum U.S., but Unum affiliate and United Kingdom and also South Carolina. The U.K. came through and supported a group that talked about return to work pathways or work pathways and a very important leverage for them was health care. Not from a cost standpoint is it for U.S. employers, but from having access to health care and what they simply did was when a person went into their return to work program, they got moved up into the q, the health care q and they got the health care service they needed faster because they're in a work program. They used that leverage to invite and incentivize the individual to participate in that work program with fairly dramatic results.

Now, as we talk about politics of incapacity and some of the definitions, I would like to just share with you what I think is a very important, simple, but critical definitions that we operate from in the private enterprise or in private disability insurance. Because what this is a relationship, a contract between us, the insurer and the employer if it's a group insurance or with the individual who is buying private individual disability insurance, is that there is an agreement. There is a contract that defines the relationship between what we will do when this person is in a situation where they're unable to work. And from that standpoint, we need to know what is the nature of that employee's work. The cost of that particular insurance would be dependent upon the risk that the person has both by age and the impairments and the work that they do. We also know there is a certain eligibility. That is, the person just doesn't get it because they are working. That employer constructs a relationship with their employee that says this is a valuable way to operate. And sometimes we have individual who is are working who are not eligible for disability.

And we're seeing interesting trends where employers are offering choices about paying for or not paying for a particular disability or health insurance. We're finding out that people oftentimes are, for financial reasons, deciding not to sign

on.

And I think that's unfortunate. I think employers have to understand the impact of overpricing or not covering the type of health care and benefits that their employee needs to be able to maintain their independence.

And then finally the definition of disability. When you become disabled, when you become unable to do your job, is it your whole job?

Is it part of the job? Any type of work? Anywhere?

These types of definitions become very important and oftentimes we don't understand what the customer actually knows. We have had situations where individuals have sued us because we made them go back to work and they didn't realize if they went back to work the benefits would stop. So the ability to understand the relationship. That there is a start and an end to the disability insurance program that the person is contracted for is an important part.

Now, what are those conditions in the Social Security disability system? Are they the same type of requirements?

No. They are different. They have different eligibility requirements. You have different types of definitions of disability and we have worked to have a good, public/private partnership that allows us to have the focus and attention make sure we are providing the right service at the right time to the right type of individuals.

Just to highlight the three elements that Winthrop talked about... Option 1 of improving SSDI claimant adjudication, speed and efficiency, from our point of view, this is absolutely necessary. We have a very important relationship with the Social Security Disability Program. We believe that we need to be part of that sharing of information, whether it's electronic medical records, the sharing of information that helps with adjudication, that helps the consumer. It is also beneficial to us and our organization as Social Security but it helps the individual because it allows for a timely, fair, accurate adjudication so that they are not inconvenienced by delays and by the sense of being unfairly treated. This starts off a relationship very poorly. The second one is a fee-for-service, early intervention, return to work services. We're open to this. We think it's a valuable opportunity for us to share some of the skills we have and I'm going to close off my time to talk about some of those specific activities that we believe will make a difference. And then the third one in terms of private administration of a public disability program is an option, but probably not a good one from this standpoint because what you're doing is not having a public/private partnership in that case. What you're doing is having a private takeover of the public system. And from that standpoint this just allows us to focus on option 1 and maybe some of the opportunities in option 2.

Now, when I speak oftentimes I run out of time. I may oftentimes ask to be a speaker either right before lunch or right before cocktail hour and so I have a lot of pressure on me to finish in a fairly timely way. And so before lunch I share with people very quickly that I have never missed lunch in my life and so we will get done on time. And then in terms of cocktail hour, well, we always like to make sure that we are completed by then because then people start leaving and it becomes a problem. So they asked me what one thing can make a difference in helping to get people get back to work and this is the one thing that we believe can be very helpful. We share this with the Social Security Administration, we share it with our employers and we include it in our disability program for our own customers and claimants, and that is the capacity to create transitions. One of the great return to work fallacies, one of the great return to work myths is that you have to be 100% and do all your job before you can come back to work. And that is simply wrong.

When is that person coming back? That's one of the fallacies of the health care system. One of the fallacies of the employers to ask when the person is coming back to work. The most important question is how. If you can tell me how a person is going to return to work or return to productivity, I can tell you when. And so that is incumbent upon any system, whether public or private, health care employer or Social Security agency is to create an opportunity by which you can create a plan of work so that both the employee and the employer and the health care provider can determine the relative success of that process.

We talk about motivation to come back to work. Motivation is a very nebulous term. But allow me to give you three elements of motivation that are very important. That is, if a person has a certain value established to an activity, it will increase or decrease their interest in going back to work. If they like work or don't like work, if they like their employer or don't like their employer, that makes a difference.

The probability of successfully coming back to work is another element. If a person feels they can't get back to work in their current condition or foresee or envision something in their head that they can't do this type of job, they won't go back to work and that becomes an important barrier that we need to pay attention to. And then the third part is the cost. If it costs too much to go back to work. If I lose too much, then I'm not going back to work. And what do we lose when we're on disability, on Social Security disability? We may lose Medicare, we may lose our health care cost. We may lose other things. What's the value in coming back to work in relationship to the cost?

So from that standpoint of transition, we need to build a public and private system that focuses on transition. The more rigid we are, the more difficult it is to move a person back to work. So keep this picture in mind. It was nothing that we created. This was a hospital that was having a lot of trouble getting nurses back to work

with certain types of impairments. And they wouldn't allow people to come back to work until they could do the full job.

Nurses couldn't come back until they could do everything a RN could do. Well, we were pretty slick. We said, "Well what do you do for the nurse that is pregnant?"

Oh, we got that figured out.

Every trimester we ratchet down more responsibilities. One, two, three steps. She's out on maternity, how do we bring her back? We just reverse the process and increase her function. This is what we do with individuals in the hospital, nurses and people within the health care industry for transitional work programs, is incrementally look at what they can do over time and then adjust the workplace to that.

We need to be specific. I'm from Chattanooga, so sometimes we have to be very specific there. The idea there is that we want to look at things that are going to create incentives. The first and foremost we suggest that any return to work program or stay at home program has to deal with the issue of medical care. We're doing a current study on cancer survivors and there are two things that are very critical in their life as cancer survivors. One is they don't want the cancer to come back. Two is losing their jobs and losing their health care.

That's important. And so health care is a dominant root and what we're suggesting is that there can be a public/private partnership with private health care groups can create transitional programs of shared risk between Medicare and private insurance to bring a person back to work in covering their health care risk. Or offer opportunities to share the risk. The big word in insurance, whether it's health care or disability or even life insurance is "sharing the risk because when we share the risk, we can manage the risk, and that's a critical part.

Support of productive aging programs. The relationship between inability to work and retirement becomes very acute after about age 50 to 55. I don't know about some of you, you look about the same vintage as I am, but when I get out of my Miata after riding with the top down and feeling very much like an 18-year-old, I have this actual cacophony of my joints trying to get out of this little car and so unfortunately those cracks and groans don't affect my work day, but at some point they may so we have to begin the process of helping employers understand the key features of productive aging program. Productive aging is not about the job. It's about maintaining one's dependence and ability to contribute with various types of impairments. Seventy five percent of our long-term disability cases are over the age of 40, 35% of our long-term disability cases are over the age of 50 and 60. That's going to probably go up 20% in the next five years because of economics and demographics of older worker. And so productive aging is a simple function of being able to look at not only the capacity to make the work environment functional for the individual, a changing functional abilities. But

also position where they can identify early potential problems through health risk assessment and then creating options. You know, when we talk about the whole idea of disability and health, one of the features that we don't pay a whole lot of attention to is the idea of hopefulness. And hopefulness is the idea of a better tomorrow.

And sometimes we can understand why people with impairments aren't very hopeful sometimes because they might not see a better tomorrow.

And so productive aging focuses on beginning to create the options of looking at opportunities for a better tomorrow that may be different than they were yesterday, different but better.

And so we have a variety of studies on productive aging that we think are important.

Sharing the risk. I'm not going to go into that today, but we have papers and discussions around that. But the offsets for Social Security and private insurance are very valuable to us because they allow us to keep the price of disability insurance down. They allow us to share the risk. Some people oftentimes criticize us because we try to move a person on to Social Security maybe too fast or maybe in an inappropriate way. We tend to disagree with that. The idea is that we want to be able to create an option that brings people back to work. And then finally, timely application...Everyone talks about early intervention. I don't know if it's early intervention or not. But it has to be optimal. It has to be at the right time and right place where the conditions are going to allow the person to move forward timely. And then finally I think this is the greatest opportunity that the public and private sector could have and that is to create a better work prescription. We focus on prescription limitations, what can a person not do? When a person goes through a Social Security evaluation and they have a certain level of impairment, we need to understand what that person can do within that impairment or within that range of function.

We find that when we have a work prescription, whether it's for a physical problem or a cognitive problem or an emotional behavioral or health problem, we are in a better position to bring resources in a better way because we know what's possible within the realm of that particular area. So we think a work prescription or that plan, the plan of how are you going to be reengaged in the workplace is a simple question that everybody should ask that individual and ask the physician and ask the employer. How can we reengage this person back into the workplace?

If an employer says, you know, really, it's the best day of my life is when this guy got on disability. He was a royal pain to start with and now you want me to bring him back?

Not going to happen. Or the physician says, you know, my practice suggest that you ought to just stay out for a long time because this is a bad employer or if the employee says or the individual says, you know, work wasn't so hot for me. I didn't really like it. I can get by under the circumstances. I'm just going to kind of stay the route. These types of questions actively engage the person to build a plan and then everybody involved can understand the progress for them. Well, how do you do that?

You have to have a dedicated team of accountability. Who does this in the Social Security disability system? The state vocational rehabilitation system has this particular opportunity. Have they met their particular obligations to do so? Some would suggest yes. Others would say no.

The degree of accountability is important and critical in any type of application of a return to work program. And then accessible...Well, there are many debates about this, where should this happen?

In our organization we do it telephonically. We don't have the resources or capacity to go into a particular locale and offer it in a specific way because our customers are spread all over the country. So we do this telephonically and we build systems and strategies to help encourage that person to move forward.

Because it's a national program, we may talk about a regionalization. We have the state programs and other areas but there may be areas where you have collaboration to create that return to work plan.

And then finally in terms of summarizing that private/public relationship, this is a slide that shares some of our data from Unum. Unum is the largest disability database outside the Social Security system.

We cover almost 23 million people and about 90 thousand employers. So we have a large insurer of almost population data. And on the left we have the Social Security results basically saying the person is no longer disabled. Where the gray shows is when they had a change in their disability status because they improved physically and the red is where they went back to work. And the combination of those two, you can see that in this case that the return to work and other conditions of the disabled in the private sector we have about a five times greater results in that particular category.

On the Social Security side, you have a much larger group of people with benefits stopped because of death and that would suggest you have a much higher severity rate of significant impairment that are life threatening. Part of that is because of the population we have. Part of it is because of the way we work in terms of our group disability programs. And then you can also see that -- where they reached retirement age, where you are dealing with a much older population than we

are, but that's going to have to change and we're going to have to pay attention to that. So this represents for us cases that have closed and opportunities for the future. And what we would like to see is two things: one is that there has to be a definition of disability that begins to focus on a way of understanding the real needs of the individual, both from the financial standpoint, but also a return to work standpoint. Some may be disabled and cannot work, but what's their future opportunity to return to work and resume a productive activity within a competitive environment?

And secondly, the lack of SSDI claims managements. We contact our claims management on long-term disability every four months. We find out how they're doing, what's important to them, what's not important this them and as that goes forward, we find that they're less able to go back to work, then we may talk with them once -- after five years we may talk with them once a year. But the idea is we're in contact with them. We think that alone can make a difference in terms of the capacity to provide and present the type of services that will make a difference that will allow the disability system not to maintain disability hostages.

Thank you for the opportunity to share these types of opinions and we hope that this is a start to the future of a future public private partnership with the Social Security Administration and the private insurers.
Thank you.

We're now going to have John Lancaster give us some feedback and do some Q&A. Thank you, John. You all set?

John Lancaster:

This is exciting. A very great forum and thank you, Winthrop and Ken, for some exciting comments and I think some real food for thought. What I find exciting about their presentations is that we're really starting to see the private sector step up and recognize and talk about solutions or begin to talk about solutions for what people of disability have known for a long time-- is that we got a train wreck here. It's been a train wreck for people with disabilities for a long time because they can't access the workplace and they're in poverty for the most part or very low income.

Now, the positive part to supporting people with disabilities pretty well is going to overwhelm both government and the private sector that's in the business of disability and health insurance.

So that to me is exciting, that we're starting to get the private sector truly engaged in this conversation and engaging with government in a big-time way. I know they have been for a number of years, but in a much more serious way.

Now, if we can get government to start responding -- I mean, we can't even get

SSA to issue the new Ticket to Work reg., so we have got some real problems within government and we've got to start figuring out how to address those.

I'm intrigued with a lot of the ideas that both Winthrop and Kenneth presented and I think there's tremendous food for thought and room to work there and conversations that should be seriously going on probably with the Congress and certainly with appropriate government agencies.

Whatever system might eventually start evolving out of the current broken one, maybe we can reinvent something here, is that it's never going to work if the individual with a disability isn't the one driving the train. There's got to be consumer control and consumer choice at the core of whatever is developed here or I guarantee you it ain't going to work.

So I think that needs to be a backdrop for whatever conversation ultimately goes on.

From the perspective of NCIL, The National Council on Independent Living, I think there are a number of things that need to be in place. Four pillars, if you will, if we're going to have an effective system of getting people with disabilities back to work.

NCIL would like to see a system in place for people with disabilities that basically has to it four very important supports if you will, or pillars, or things that we feel need to be effectively in place if we're going to achieve what we want, and that's to get people with disabilities who are at all capable back into the work force and as productive as possible so that they can be maximizing their personal potential and obviously having income in their pockets.

And the first of these is we have got to come to rest, once and for all, with the issue of health insurance and covering people so that they have the requisite health care supports that they need to go back to work. And that includes things like long-term care supports. If you're a quadriplegic or someone with a disability or some other form of disability that needs a personal care attendant, that system is going to have to be there to enable that person to go to work.

Second, government is going to have to address, particularly if we're expecting medicare to be part of this health insurance picture, a lot of different issues including issues like being the home rule and things like that are making it difficult for people to get the durable medical equipment and other supports that they need to not only allow them to get to work, but to work as effectively as possible at that work site.

So there is a lot of work that still needs to be done in the area of health insurance and fortunately there seems to be some new momentum and initiatives to start

trying to tackle this issue. We're just going to be in there fighting to make sure people with disabilities, particularly those who want to return to the work force, are not left out of that picture and are getting the appropriate consideration that they need.

So health care.

There needs to be a strong, effective and reliable system of income replacement insurance. We have a fairly good one now, SSDI, that everybody claims is broken and is not working as we saw in the demographics and overload in terms of its cost. But some sort of income replacement insurance has to be in place for those people who truly become so disabled that their perspective of earning a gainful living is just not there.

And there are a few people out there. Many people that think that, including people with disabilities themselves. But there are people out there that for whatever reason are going to need a system of income replacement insurance.

Second in this area of insurance what we need to develop desperately is income support insurance. We need to have insurance that will insure people to go back to work, not insurance that encourages people or forces people worse yet to not go to work. And right now, that's what the system does. First and foremost, to get SSDI or SSI if you're an adult for that matter, you have to go before the Social Security and put up your hand and say I swear, I am too disabled to work.

Well, what's that got to do with the sorts of things that Ken was talking about when he was talking about value and expectation and cost that the individual is ultimately evaluating before he makes that choice? He's just declared to himself and to a government agency that he can't work or she can't work. Pretty soon, you start to believe that.

So we need to change the whole concept here and we cannot be basing the systems on a person having to go someplace and declare that "I'm too disabled to work" and then try to patch that up by saying "Oh, well, if we do a pass program or we do a ticket over here and we do a this over there and do a that over there, then maybe we can figure out a way for you to get in and work for maybe part of the week or the other part of the week or work and then when you get to a certain point, we'll cut off your benefits and you'll be working but you'll be working in ways that keeps you in poverty." There is a lot that needs to be done there and I maintain that we need a national system of income support insurance that's going to be spread out over the entire work force, whether that's a combination of private sector and public sector or how you do that, I don't have the answers to that. Don't presume to. But we need a system of income support.

Third is I think -- the third kind of pillar if you will or major thing is we maintain

that you need to build some incentive in here beyond some of the things that Ken and Winthrop spoke about for the employer to be hiring people with disabilities. You've got to make existing tax credits true credits to start with so that even if the employer, say they are a small business, doesn't owe any taxes at the end of the year, or very little and doesn't really qualify for the credit that they would like to take because they made their facility accessible for a disabled worker or whatever, well, give them a check. Build in other incentives in the tax code that make it worthwhile for the employer to take a chance that many are afraid to take on investing in that individual with a disability and they're generally afraid to take that chance because of attitudes, conceptions or preconceptions about what people can and cannot do, the low expectation that our country generally has around disability.

I maintain that you've got to overcome that with some true incentives. Cash incentives are not there for the employer now. In fact, we missed a really great opportunity with the Ticket to Work Act. Duke the Ticket to Work -- do you think the ticket to work would be working better if employers had been allowed to take the ticket directly from the individual with the disability?

I maintain that if the regulations had been written so that individuals could take their ticket, go right to an employer that they wanted to work for and hand the ticket to that person and you got a wage offset, that we'd have a real program going. I could be wrong. But there would be some real cash incentive there for the employer and they could do the on the job training or whatever would be necessary to make that happen.

On the flip side of that, I think there needs to start being some tax incentives for people with disabilities because many people with disabilities in order for them to work bear significant additional costs that coworkers without disabilities do not have to bear. And they come in all sorts of different forms. A lot of them are reliant on durable medical equipment or to other supports that possibly could be covered by a good health care system, health support system and some are not. So, again, I think you need to be providing incentives for people with disabilities to step out and to take that chance that many have been afraid to take.

And then four. I think the fourth sort of pillar is we have got some serious work to do and this is where we might be learning some things from the private sector. In particular is the public rehab system and the education systems got a lot of work yet to do in terms of thinking about what it is that they need to be doing to get people ready to either go back to work or in the case of young people, to go to work for the first time in terms of gainful employment.

So those would be the concepts that we feel need to be in place. From our perspective, key to all of this, whatever system ultimately comes out of what I hope is a growing dialogue and a lot of things have been happening lately with

the Social Security Advisory Committee, which I know Andy and probably others in this room are connected with. The work that Jill Houghton and the Ticket to Work workforce incentives advisory panel have been doing and some of the other things that are being talked about, most importantly this effort that AARP and Cornell University have been doing for a while now is that I think we have got a dialogue that's starting to happen and we need to make it a part of that dialogue that the individual with the disability has to be driving the train and has to be the one that's ultimately in control of their own situation and their own things. And I think whether it's a private disability insurance plan, a contract with a union or employer, whether it's a government program, that needs to start being built in to the core of the program. So with that, I think it's time to turn it over to questions for the people who are playing music.

Questions from the audience

Okay. Questions, we'll take questions. Ray? Ray Glazier is back there with his hand up.

Hi, Ray.

Ray Glazier:

Ray Glazier with the associates...(In audible question)

David Stapleton:

I'm not sure if everybody can hear that. I think it was more of a comment than a question. The importance of family health insurance benefits for people with disabilities along with disability insurance in terms of them being able to continue the work if they do have a disability. We have been working with Ray on the Offset National Administration for the Social Security Administration and we grapple with that. Any of the presenters want to comment on that? Winthrop, Ken, did you want to comment?

Ken Mitchell:

Just a brief comment.

As I mentioned earlier, the American Health Insurance Plan work in the area of disability, but also in the area of health insurance. I also have an Unum plan that would replace 60% or 2/3 of income if I become disabled and have to leave the work force.

The offset issue that you raise, the benefit levels for disability income replacement need to be carefully set to have the appropriate incentives that plain old individuals who access those benefits. While we certainly understand your concern about medical expense insurance, the answer is not to do away with the offset. The answer has to be someplace else and it's not in my portfolio to discuss this. But

America's Health Insurance Plan is working hard with its members to reach people who have a lack of access to medical expense insurance on a number of medical fronts. And they have unveiled a campaign to expand medical expense insurance to the people who don't have it and to work with states for that kind of reform. Also, you know you mentioned Social Security. There is of course as you well know the waiting period, the 24-month waiting period. Another area of public policy rather than doing away with the offset would be to do away with the waiting period. And that's something that of course has raised a flag. That's -- from time to time. That's more a more direct, more appropriate way to get at this issue.

David Stapleton:

Thank you. Another question?

Yes?

Linda Bergofsky:

This is Linda Bergofsky from Health and Human Services and this is a question for both Winthrop and Ken. Before I came into here, I was at the benefits consultant looking at paid time off, disability and insurance planning and one of the things that you didn't address is when an employer's STD, LTD and health insurance are offered by different carriers and they themselves aren't interoperable. They have different expectations about return to work or worse yet somebody has an STD plan but don't have an LTD plan, you know, there's all sorts of things that are going on there. So I guess my question is how does your proposal or your thinking about taking on the administration of SSDI affect employers if they don't have all three pieces or they have three pieces covered by different carriers? And then the second part of my question is where do unions come in? Because you talked about the politics of incapacity are driven by things that employers cannot control and let's say unions are one of them.

Ken Mitchell:

It's probably more common than you think where an employer has multiple vendors and it's just one of the realities of the benefit world and certainly we encourage coordination integration of STD, LTD and family medical leave. There was a time back five years ago where the discussion was to include workers' compensation and that has some value. But we find that if you can integrate the family medical leave administration short term disability and long term disability, then the employer has the choice to bring it -- but the whole idea of silos has been a historical posture that employers have taken, and vendors have taken to get a better deal. It's a financial question or someone has a brother-in-law that says STD and then an uncle that says LTD and we go that route or a neighbor. So the employer has to make the decision on a benefit strategy that is best for them and that's what we try to encourage through education and research and things like that.

The union side is a very important one because the union has a voice at the table and so but often times we find that unions will try to set up a benefit plan for their members that's attractive and often times doesn't include return to work. It just says get the biggest benefit you can and go with that. So once again, it's the same situation of educating union officials that really is not a matter of income replace. It's a matter of bringing a full source -- because they have to understand if their person doesn't come back to work and leaves the company, they no longer have a member and so the union ability to have a well-developed, well-thought out resource for their member is an important aspect too and then just -- let me just put that in effect. When we look at transition 23458 work programs, if you want to look at one of the best ones, go to the master friend group for the teamsters. They have one of the best well-defined, well-articulated transitional work program for their members and so we see some very significant, insightful visionary type of languages with the labor management contracts and if you have a union, we encourage employers to build it into the agreement. Rather than fighting it, build it into the managing plan.

Susan Web:

Dave, it's Susan. I have a question.

David Stapleton:

Go ahead.

Susan Webb:

Hi. It's Susan Webb and I'm representing the Arizona Bridge Independent Living, one of the few independent networks under the Ticket to Work that is making success of that program and getting people back to work successfully. I think my question is to Winthrop. By the way, your presentations were wonderful. Very, useful.

But Winthrop in particular, one of the things that we see in returning people to work that was kind of touched on a little bit by both of you, but I think it wasn't real honed in on and that is the role of the health care practitioner. Many people with disabilities understandably needs to see certain specific doctors, podiatrists in particular. Yet other health care practitioners and psychiatric practitioners as well are really not very good at return to work. They really are more inclined to take the safe road and tell people to stay off work, not encourage them to go back. And I'm wondering in the private sector, and LTD in particular, you guys have found some magic buttons that, you know, or if you have an education program out there with health care practitioners to encourage them to really focus on work and to involve others in the community and the employer more in terms of really looking at the job task. As we know of course if someone has a disabling condition that maybe might prevent from continuing, might not be able to go back to their condition, but can do other things. What are you doing in the private sector to

help overcome that health care practitioner's tendency to tell people to stay off work?

Winthrop Cashdollar:

Thank you for your question and it is an excellent one. I will try to address part of it and see if Ken wants to really address it because he's the return to work guy.

Ken mentioned I think the word, or the phrase, work rx and I think that's a good concept. You're right, many physicians feel or think that they are doing their patients a service when they reflexively encourage them to stay out of the workforce. But in fact there are lots of reasons why return to work should be a medical outcome that physicians do consider. There are financial reasons, psychological reasons, emotional reasons. And it's pretty clear that that's not the current mind set of treating physicians.

We have begun -- we have only just begun to work with our own medical directors with disability insurers and also some people in the public sector to see if there can be better physician education. The physician education that we envision would start with disability determination. And therefore would reach a certain subset of the physician world. But I can see an element of dimensional physician education tool or resources that could help focus in on the desirable, therapeutic desirability of return to work.

So, Ken?

Ken Mitchell:

There are three specific programs that are being put forward out in the private sector. Those physicians that use evidence-based medicine get a performance payment for using that, where the employer and their health care provider invite that particular individual health care provider to use a set of evidence-based medicine guidelines that encourage the development of return to work plan, whether it's a person with depression or behavior health problem, muscular skeletal problems, whatever the case may be. There are plans within the medical treatment plan.

A second group that needs to be paid attention to is ACOEM. They came out in 1996 with a very well structured document that's being applied across the country for occupational and environment medicine and there are programs that help them to understand what they need to do to create the right type of practice patterns to support return to work and then the third group is a very specific group called Web Building, Webbuilding.com. Jennifer Christian, Dr. Christian is one of the leading authorities in helping physicians upon building the best practices to bring their practice back to work and then what we encourage, especially with hospitals is to offer a return to work grand rounds. Continuing education for physicians is critical and so they have to have it every month and hospitals offer it

every month. So rather than just dealing with specific clinical activities, offer at least once a year, maybe twice a year, a topic on how to bring your patient back to work. Because I guarantee you if you have an individual struggling to go back to work, the employer is feeling the frustration, but the physician is feeling frustrated because they can't move them forward.

So these types of continuing education programs as specific as they are and applied can really make a difference and we're very pleased to support those types of programs. That's Webbuilding.com and Dr. Jennifer Christian and ACOEM, American College of Environmental and Occupational Medicine. Some very specific programs that anyone can be able to apply at a local level.

Susan Webb:

Do you know the ACOEM website?

Ken Mitchell:

Just go to American College of Environmental and Occupational Medicine, ACOEM, or just google it and that will bring you to that right approach and I suspect they have that document on their website that you can download and it's probably the best developed document talking about how physicians can help deal with disability in the workplace and in their patient population.

I will mention that the work on the national demonstration which I hope SSA will release the report on soon. Jennifer Christian was one of the people involved in doing the demonstration and addressed the family benefit design issue as well. Yes?

David Stapleton:

Actually, it's 3 o'clock now, but we started late and I'm happy to go for 10 or 15 more minutes unless we have to get off the phone. Can we do that, Brewster, if we can stay?

Carol Boyer:

Hi, my name is Carol Boyer and I'm with the Office of Employment Policy at the Department of Labor. There is a lot of work to be done. I don't know where to start because I have been in this field for 22 years as some of you have been in longer than I and I know a lot of you here and all of the things that you all have said, we have heard them, 25 years plus and nothing much has changed. We have perceptions of people with disabilities that don't think they can work because society has mold them to I can't work. You have got physicians that write a prescription for them and this is just a small thing. These are all wonderful programs but we have known this for more than 20 years that doctors tell their patients or employees you should just take your disability and get out of work, just take the disability. Most physicians don't know what assistive technology is even out there. They have no idea. The University of Colorado is one of the only

medical schools in the country that has a program that the medical school has to take on assistive technology and then you have got private employers, public employers and the disability insurance, the perception of disability, the varying definitions and I believe I talked with Ken on the phone a few years ago and I worked with a few of your colleagues and we had a wonderful discussion about that.

So we have got all these perceptions. You have got insurance companies that don't work the same. Health insurance companies don't work the same as disability insurance and they have got to talk together because disability insurance wants to get people back to work, but the health insurance that gives people supports to fix their hip, get them the assistive technology they need to do their job, whether it's a vehicle so they can get to work, whether it's hip replacement or whatever technology they need, they follow medicare, medicaid, they follow them and they don't look at helping people with disabilities to make their lives improved the same way as the DI insurance do and they are starting to talk together. But it's quite interesting what the health insurers don't look at. They look at surgery differently than assistive technology, but the result is the same. And my good friend Steve Mendelson, who many of you know, says we've got to turn this paradigm on its head because the result is the same but it's how you pay for it to get to getting people independent insurance and I love that term, changing it from disability to independence and I don't know where to begin, but I have heard so many people on the phones. I used to work for the ADA hotline at DOJ and so many employers say to their employee, you can't come back to work until you're 100%. My god, even on my best day, even with or without a disability, I'm never 100%. Who is?

Who is whether you're coming back from a vacation or coming back from health issues or whatever or childbirth, whatever it might be. I don't think anybody is 100%. Even our computers that are supposed to be 100% break down and we have to reboot them. Nothing in this world is 100%. So I don't know where that came from, but I'm glad that we're making end roads. I'm glad that there is discussion, there's dialogue going on and I just think we get there, but it may be another 20 years, but we are getting there and we're moving.

Margaret Campbell:

Yes, my name is Margaret Campbell. I'm from The National Institute on Disability and Rehabilitation. That's part of the U.S. Department of Education and we're in the Office of the Office of Special Education and Rehabilitative Services which include RSA.

Hard act to follow, but I want to pick up where you said there's so much that needs to be done and this is really kind of an unfair question. But to Winthrop and to Ken, from your various roles that you play, various I should say portfolios you manage and issues you deal with, I'm sure that maybe not on a daily basis, maybe on a weekly or monthly basis, issues arise where you say to yourself that's

an area where we really need some research. So my question is short of the large-scale demonstration projects that will require SSA, what do you see or what comes to your mind as some of the key strategic research questions or issues that could really, from your perspective, really contribute to advancing either the public/private partnership concept, the return to work issues? Just if you could share some of those thoughts in terms of the research side of this. What evidence? What strategic evidence from a research perspective would help advance some of these issues?

Winthrop Cashdollar:

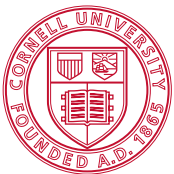
Well, thank you for the question. I want to go back one comment briefly and then I'll say I suppose it's evident that progress, to the extent there has been progress, has been painfully slow. And I could say that nothing will get better for another 20 years but I don't believe that. I think for one thing there is a confluence of circumstances coming together and necessity being one of them. Necessity the invention and fiscal and demographic trends facing both the public and private sectors will force some change. The other has to do with assistive technology and I think the exponential nature of transformation in certain technology is really going to ripen some things and not only within our lifetime very soon, and that could be something that will bring surprising results. I have seen and I can't explain this so I won't try. But I have seen technologies that are in use now that are available and will bring significant changes in our lifetime in terms of health and function.

But to Margaret's question and I'm going to couch this in terms of doing or getting better information than we have now because I'm not sure that I'm aware of everything, but we have -- at AHIP, we started to do research on return to work, trying to quantify the effort, to quantify the outcomes across the industry, to get qualitative information on what works and what works better than other things, and I would say that there's not as much information as I think there needs to be or as I would like to see. We also want to try to do a better job even quantifying and characterizing the economic impact of rehabilitation and return to work. Impact on employers, individuals but also public programs. I think we can do a better job there and tell a better story. Ken?

Ken Mitchell:

In my day to day life at the organization and then looking at the broader perspective, I find employers have a hard time digesting research from the outside because it doesn't pertain to them, big groups. Doesn't make sense.

So, Margaret, in my life, what I try to do is I'm exploring the capacity to invite that employer to use their own employees to understand exactly what winthrop said, why do some employees come back to work and some don't? Is it a benefit issue? Is it a health care issue? Or is it a changing motivation of the individual issue?



Cornell University

For more information about the Rehabilitation
Research and Training Center on Employment
Policy for Persons with Disabilities contact:

Susanne M. Bruyére
Employment and Disability Institute
Cornell University
201 ILR Extension Building
Ithaca, New York 14853-3901

Tel	607.255.7727
Fax	607.255.2763
TTY	607.255.2891
Email	smb23@cornell.edu
Web	www.edi.cornell.edu